Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 03/12/01.
   b. The request was received on 02/13/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
   a. TWCC-60 and Letter Requesting Dispute Resolution dated 02/13/02
   b. HCFA's
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:
   a. TWCC-60 and Response to a Request for Dispute Resolution
   b. HCFA's
   c. Audit summaries/EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307(g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 05/15/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 05/16/02. The response from the insurance carrier was received in the Division on 05/30/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: per letter dated 02/13/02
   "The treatment received was medically necessary, pre-authorization was received, and billing was done in accordance with TWCC fee guideline."

2. Respondent: no position statement submitted

IV. FINDINGS

1. Based on Commission Rule 133.307(d)(1&2), the only date of service eligible for review is 03/12/01.

2. The EOB for the date of service in dispute **G** – "UNBUNDLING" & "INCLUDED IN ANOTHER BILLED PROCEDURE" and **M** – "NO MAR, REDUCED TO FAIR & REASONABLE".

3 The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code	MAR$	REFERENCE	RATIONALE:
03/12/01	99499-RR	$800.00	$100.00	M	DOP	Texas Workers' Compensation Act & Rules, Sec. 413.011(d), Rule 133.307(g)(3)(D)	The provider has not submitted reimbursement data that would indicate the amount of reimbursement requested is fair and reasonable or that the amount received is not fair and reasonable. Therefore, no additional reimbursement is recommended.
03/12/01	99070-AS	$325.00	$115.00	M	DOP	Texas Workers' Compensation Act & Rules, Sec. 413.011(d), Rule 133.307(g)(3)(D)	The provider has not submitted reimbursement data that would indicate the amount of reimbursement requested is fair and reasonable or that the amount received is not fair and reasonable. Therefore, no additional reimbursement is recommended.
03/12/01	A4646	$186.40	$50.00	M	DOP	Texas Workers' Compensation Act & Rules, Sec. 413.011(d), Rule 133.307(g)(3)(D)	The provider has not submitted reimbursement data that would indicate the amount of reimbursement requested is fair and reasonable or that the amount received is not fair and reasonable. Therefore, no additional reimbursement is recommended.
03/12/01	76000-27	$203.00	$0.00	G	$88.00	TWCC 97-01, MFG, CPT descriptor	The referenced Advisory allows reimbursement for fluoroscopic assistance. Per the MFG, the provider is due reimbursement of **$88.00** for the billed technical component.
03/12/01	99070-SN	$115.00	$0.00	G	DOP	MFG, SGR (V)(B)(1-3)	The CPT code in dispute is not one that is reimbursable per the referenced SGR. Therefore, no reimbursement is recommended.
03/12/01	A4649	$106.00	$0.00	G	DOP	MFG, GI (III)	The provider's dispute packet does not contain adequate documentation of the material used or its value. Therefore, no reimbursement is recommended.
03/12/01	99070-IV	$22.60	$0.00	G	DOP	MFG, SGR (V)(B)(1-3)	The CPT code in dispute is not one that is reimbursable per the referenced SGR. Therefore, no reimbursement is recommended.
Totals		$1758.00	$265.00				The Requestor is entitled to additional reimbursement in the amount of $88.00.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $88.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 6th day of August 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.